STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155756	B. WING		10/19/2012	
				ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF F	PROVIDER OR SUPPLIE	R		V JEFFERSON BLVD		
COVENT	RY MEADOWS			WAYNE, IN 46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
F0000	This visit was for State Licensure  Survey Dates: Grand 19, 2012  Facility Number Provider Number AIM Number: Survey team: Julie Wagoner, Tim Long, RN Christine Fodre.  Census bed type SNF: 27 SNF/NF: 107 Total: 134  Census payor ty Medicare: 24 Medicaid: 66 Other: 44 Total: 134  These deficience cited in accordars.	or a Recertification and Survey.  October 15, 16, 17, 18,  r: 004945 er: 155756 200814400  RN, TC  a, RN e:  rpe:	F0000		DATE  Dof oot s  on of ble y yey,	
	Quality review of Cathy Emswille	completed 10/29/12 or RN				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

004945

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155756	A. BUILDING B. WING	00	— COM	TE SURVEY  1PLETED  19/2012
COVENTI	ROVIDER OR SUPPLIE	R	7843 W	ADDRESS, CITY, STATE, ZIP JEFFERSON BLVD VAYNE, IN 46804	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YQ0S11

Facility ID: 004945

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155756	B. WING		10/19/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		V JEFFERSON BLVD	
COVENT	RY MEADOWS			WAYNE, IN 46804	
				T	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F0279			TAG	BENELINE TY	DATE
SS=E	483.20(d), 483.2	IPREHENSIVE CARE			
33-E	PLANS	II NETENOIVE GARE			
	_	se the results of the			
		levelop, review and revise			
	the resident's co	mprehensive plan of care.			
		develop a comprehensive			
		ch resident that includes			
	-	ectives and timetables to s medical, nursing, and			
		chosocial needs that are			
		comprehensive assessment.			
		·			
	'	ust describe the services			
		nished to attain or maintain			
		ghest practicable physical,			
		chosocial well-being as 483.25; and any services			
		wise be required under			
		not provided due to the			
	_	se of rights under §483.10,			
		nt to refuse treatment under			
	§483.10(b)(4).				
	Based on reco	ord review and	F0279		11/18/2012
	interviews, the	e facility failed to ensure		F 279 Develop Comprehensi	ve
	care plans rela	ated to behaviors were		Care Plans	
	initiated timely	and/or were		It is the practice of this facility	
	individualized	for 6 of 10 residents		develop, review and revise ear resident's comprehensive plan	
	reviewed for u	nnecessarv		care using the results of the	
		(Resident #18, 41, 80,		assessments completed on ea	ach
	151, 175, and			resident. The care plan will	
	101, 170, and	241)		include measurable objectives	3
	Findings inclu	de:		and timetables to meet each	
	Findings inclu	ue.		resident's needs in the followi	9
	1 The -!!!	I was and fan Danidant		areas; mental, psychosocial, a medical.	ING
		I record for Resident		medical.	
		wed on 10/18/12 at		What corrective action(s) will	ıı
		sident #41 was		be accomplished for those	•
	admitted to the	e facility on 07/27/12		residents found to have been	n

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Event ID: YQ0S11

Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPLI	ETED
		155756	A. BUILDING B. WING 10/19/2012			2012	
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON BLVD		
COVENI	TRY MEADOWS			FORT	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	from an acute	care hospital. The			affected by the deficient		
		noses included but			practice:		
	_	d to: Acute T2 T3					
		cture, falls, dementia,			· Interdisciplinary Team		
					(IDT) will review residents #18	5,	
	osteoporosis, (	-			#41, #80, #151, #175, #247		
	venous-statis,	•			affected by the alleged deficie	nt	
	syndrome, and	I compression fracture.			practice and update the care plans to the individual needs of	, l	
					those residents in accordance		
	Nursing progre	ess notes, dated			with the specific behaviors that		
		16 P.M. indicated the			are listed for that resident.		
		pset about being at the			Social Services will discuss wi	th	
		nted to go home. She			the psychiatric clinician on or		
		eelchair backwards into			before 11/18/12 regarding		
					psychotropic medication		
		tration and the handle			management for those resider	nts	
	of the wheelch	air put a hole in the			that were affected and make		
	wall.				necessary changes as		
					recommended by the psychiat	ric	
	On 08/04/12 a	at 10:06 P.M., the			clinician or neurologist.		
		ne upset because her			How will you identify other		
		contain all of her			residents having the potentia	.	
		dition the resident			to be affected by the same	<sup>21</sup>	
					deficient practice and what		
	continued to w	ant to go home.			corrective action will be take	n·	
	On 08/05/12 at	t 6:37 P.M., the			No other residents were	,	
	resident was a	gitated again and			found to have been affected b		
	wanted to go h	ome. She kept asking			the alleged deficient practice.	<b>´</b>	
		her a ride. An order for			· Residents having		
	Ativan was obt				psychotropic medications have		
	, tavan was obt				the potential to be affected by	the	
	On 00/06/40 at	t 10:00 D M the			alleged practice.		
		t 10:00 P.M., the			· Licensed staff and		
	_	expressed the desire			members of the interdisciplina		
		Staff explained why			team including social services be in-serviced on the behavior		
	she was at the	facility and gave her a			management program includir		
	pain pill and sh	ne was calmer.			development of the	ษ	
	' '				comprehensive care plan.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155756	B. WING		10/19/2012
NAME OF I	DROLUBER OR GURRI IEI		_	EET ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	PROVIDER OR SUPPLIE	К	784	3 W JEFFERSON BLVD	
	RY MEADOWS			RT WAYNE, IN 46804	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	IATE CONTENT
TAG		R LSC IDENTIFYING INFORMATION)	TAG	<u> </u>	DATE
		t 1:09 P.M. the resident		Education will be provided by Social Services	<i>'</i>
		et about the "missing		Consultant/Designee and	
		closet and wanted to		completed by November 18	th ,
	_	order for a urinalysis		2012.	
	was obtained.			· A house audit will be	
				implemented by Social Servi	
		t 12:22 A.M., Resident		and will begin using a tool fo tracking of psychotropic	ſ
	#41 was agitat	ted again about her		medications for all residents	who
	missing clothe	s. The resident thought		are on psychotropic medicat	
	she was "at ho	ome" and her clothes		to ensure that all behavior	
	had been take	n from her closet. The		management and comprehe	
	nursing staff e	xplained she only		care plans are in place in a t	
	_	s and two were in the		fashion and individualized fo each resident. All new	ſ
		re in the hamper, and		admissions and readmission	s are
		laundry. The resident		reviewed in a.m. meeting wit	
		ad a "whole closet full		to ensure the care plan,	
		staff then "quizzed" her		diagnosis, behavior tracking	
	about the nam	•		sheets are individualized and	d in
		g facility resident had		place. See Exhibit A.	
	been residing	•			
	Jeen residing	in prior to rail).		What measures will be put	into
	On 08/00/12 a	t 9:22 A.M., the		place or what systemic	
		,		changes will you make to	
	_	began repeatedly "things." She indicated		ensure that the deficient	
		5		practice does not recur:	
		es, her purse, and her		liane l - t-ff l	
		Staff attempted to		<ul> <li>Licensed staff and members of the interdisciplir</li> </ul>	an/
		sident but she became		team including social service	-
	, ,	t, did not believe the		be in-serviced on the behavi	
	1	ner items had been		management program includ	ling
		sident was given Ativan		development of the	
	to help her "re	st."		comprehensive care plan.	,
				Education will be provided by Social Services	<i>'</i>
	On 08/12/12 a	t 11:16 A.M., the		Consultant/Designee and	
	resident starte	d asking to go home.		completed by November 18	th ,
	The resident a	sked staff and visitors		2012.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DINI DDIC	COMPLETED	
		155756	A. BUILDING		10/19/2012
			B. WING	ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
COVENT				V JEFFERSON BLVD	
COVENT	RY MEADOWS		FURT	WAYNE, IN 46804	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	for a ride home	e, asked to call her		· IDT to review all	
	family. She the	en became agitated		medication orders using the to	ool
	because she w	vas not in her "home."		for tracking of psychotropic	
	She was redire	ected and informed		medications to ensure behavior	or
		and therapy would		comprehensive care plans are	_
		sue with her tomorrow		individualized and initiated tim	
				including by not limited to	- ,
		her discharge plans.		diagnosis, behavior flow shee	t
	· ·	he resident became		listing the specific behaviors to	
	_	oud, tried to exit the		support the diagnosis and	
	facility repeate	dly. The resident was		indication for psychotropic	
	medicated with	n Ativan for anxiety and		medication. See Exhibit A	
	given 1:1 atter	ntion which was		·DNS is responsible to over	see
	effective.			compliance.	
				How the corrective action(s)	
	On 08/13/12 th	ne resident's attending		will be monitored to ensure	
		r Haloperidol, an		deficient practice will not red	
		nedication and		i.e., what quality assurance	, l
		antidepressant		program will be put into place	e:
		•			
	medication wit	h sedating side effects.		·A CQI monitoring tool calle	d
				Psychoactive	
		note, dated 09/07/12,		Medication/Behavior	
		laloperidol was ordered		Management will be utilized e week x 4, monthly x 3 and even	
	due to "delusio	onal disorder."		other month x 3 for at least 6	ery
				months. See Exhibit B	
	On 8/31/12, a	note to physician,		Data will be collected by	
	· ·	resident continued to		DNS/Designee and submitted	to
		behaviors through past		the CQI Committee. If thresho	
	•	ing and hitting staff		of 95% is not met, an action p	lan
		•		will be developed.	
	•	I't open the door for her		Non-compliance with facility	У
	or ask her to s			procedure may result in	
		sked to change Haldol		disciplinary action up to and	
		e to Risperidone. The		including termination.	
	request was no	ot responded to by the			
	physician.			Completion Date 11/18/12	
	-			Completion Date 11/10/12	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE	
AND PLAN	OF CORRECTION	155756		LDING	00	10/19/2	
		100700	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/10/2	
NAME OF P	PROVIDER OR SUPPLIEF	R			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
1710	On 08/24/12			1710	·		DATE
		ated the resident has					
	1	olem behaviors in the					
	1	e was "exit seeking,					
	· ·	nto staff, scratching,					
	_	taffher moods					
		MAtivan seems to					
	help her to calı	m but takes awhile."					
	Review of the	behavior tracking for					
	Resident #41 f	or August 15 - 31,					
		it tracked the following					
	behaviors:						
	1	b [as evidenced by] [as					
	· -	[as evidenced by] [as					
	· -	[as evidenced by]					
	•	vorrisome thoughts					
	and	e stealing her things					
		aeb [as evidenced by]					
	<del>-</del>	by] [as evidenced by]					
	l =	by] [as evidenced by]					
		- 8 hours daily.					
		behaviors noted on					
	ine tracking for	m for August 2012.					
		12 behavior tracking					
		the following behaviors					
	were being trac						
		b [as evidenced by] [as					
		[as evidenced by] [as					
	· -	[as evidenced by] vorrisome thoughts					
	•	e stealing her things					
	j such as people	sicaling her tillings					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/19/2012
NAME OF	PROVIDER OR SUPPLIE		B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	1
	TRY MEADOWS			V JEFFERSON BLVD WAYNE, IN 46804	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	COMPLETION COMPLETION
TAG	#2 - Insomnia	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	#3 - Verbal an agitation/aggre	. •			
	care plan to ad behavior for w being adminis addition, prior	behavioral tracking or ddress the delusional hich the resident was tered, Haldol. In to the order for the was no documentation lisorder			
	plans for Resign included a plans for aggressive initiated on 08 and a plan, initiated prior to administration	current heath care dent #41 indicated they n, initiated on 08/20/12 behaviors, a plan, /15/12 for insomnia, tiated on 08/15/12 for e were no care plan o the obtaining and of both antianxiety, and/or antidepressant			
	employee #9 a Consultant, er 10/19/12 at 11 the physician was resident while living facility hand indicated delusions. The indicated she was consultated to the consultate of	Nursing Consultant, and Social Services apployee #10, on :00 A.M, indicated who had taken care of she was in an assisted ad ordered the Haldol the reason was e Nurse Consultant was checking with the see if there was anymore			

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155756	B. WIN	IG		10/19/	2012
NAME OF P	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
00\/ENT					JEFFERSON BLVD		
COVENT	RY MEADOWS			FORTV	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+-	TAG	DEFICIENCI)		DATE
		e reason Haldol was					
		e was no further					
	information obt						
		e time of the survey					
	exit for the faci	iity.					
	O The elimical	record for Desident					
		record for Resident					
		ved on 10/18/12 at esident #18 was					
		e facility on 05/22/2008,					
	_	including but not					
	and decreased	ression with withdrawal					
		·					
		flux, personality					
		orderline features, hx					
		y, ddd, htn, moderate					
	•	sed cholesterol, djd,					
		lar disorder, delusions,					
	_	allergies, dry eye, oad,					
	nypenipidemia	, and diabetes mellitus.					
	Daview of the	abyraiaian andara far					
	·	physician orders for ndicated she was					
	_	ictal, a mood altering					
	•	zaclo, an antipsychotic					
	· ·	amenda, a medication					
		tia, and Exelon patch,					
	i an anddepress	ant medication.					
	Dovious of the	current behavior					
	_	ealth care plans for					
	•	current for October					
	2012, indicate	•					
		e being tracked:					
	#1 - Hx of alter	ation in mental process					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155756  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING D. COMPLETED 10/19/2012  STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  (X5) COMPLETION COMPLETION DEFICIENCY COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  STREET ADDRESS, CITY, STATE, ZIP CODE  7843 W JEFFERSON BLVD  FORT WAYNE, IN 46804  (X5)  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS  7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  (X4) ID PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLETION
COVENTRY MEADOWS  FORT WAYNE, IN 46804  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH DEFICIENCY MUST BE PRECEDED BY FULL)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH DEFICIENCY MUST BE PRECEDED BY FULL)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION (EACH CORRECTION COMPLETION COMPLETION COMPLETION CORRECTION COMPLETION COMPLETIO
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION
TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   DEFICIENCY)   DATE
with potential for injury to self, family members and/or staff and #2 -
Manipulative behavior.
Wampalative behavior.
Interview with Social service
designee, employee #5, on 10/19/12
at 11:00 A.M. indicated she had not
been working in the facility very long and was not able to discuss behavior
tracking and antipsychotic medication
use for Resident #18.
Interview with the Social services
consultant, employee #10, on
10/19/12 at 11:10 A.M., indicated the
care plan regarding behavior tracking
for Resident #18 was not clear as to what to what the actual behavior
being tracked.
3. The clinical record for Resident
#175 was reviewed on 10/18/12 at
2:30 P.M. The resident was admitted
to the facility on 10/19/11 and
readmitted to the facility on 07/02/12 with diagnosis, including but not
limited to falls with fracture and scalp
lacerations, senile dementia,
insomnia, anemia, anxiety, and hx of
urinary tract infection.
Dhusisianta andam datad 04/20/43
Physician's orders, dated 04/20/12 indicated an order for Ativan .5 mg
every 8 hours as needed for anxiety.
On 05/03/12 an order was received

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPL	
		155756	A. BUII B. WIN	LDING G		10/19/	2012
	PROVIDER OR SUPPLIER		•	7843 W	DDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	routinely for an order to utilize could be used insomnia, along ordered Ativan did not receive Ativan in a 24 ft. A care plan reginitiated until 00. The resident wacute care faci Physician orde indicated the reactivan, an antiativice a day and and/or agitation depression, an Remeron at be On 07/09/12 at hypnotic was of a family request 07/11/12, the Adiscontinued at received for Tybedtime, may redue to insomnia. On 07/27/12 at Lunesta 2 mg afor insomnia, a	garding anxiety was not 6/29/12.  as readmitted for an lity on 07/04/12. Ity on 07/04/12 esident was receiving anxiety medication, d as needed for anxiety in, and Exelon patch for d an antidepressant, dtime.  In order for Ambien, a redered at bedtime per est due to insomnia. On ambien was and an order was lenol PM one tablet at repeat one time a night					

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Event ID: YQ0S11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

of correction (X1) provider/supplier/ci identification number: 155756		MULTIPLE CO JILDING NG	00	COMPI 10/19	LETED
PROVIDER OR SUPPLIER  RY MEADOWS	•	7843 W	ADDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD VAYNE, IN 46804		
RY MEADOWS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL also added.  Review of the care plans for Resident #175 indicated plan, current through 12/11/12 for Behavioral symptoms signs and symptoms of anxiety, insomnia, and depression. The one plan to address restless leg syndroming indicated a plan to administer the medication. No non-pharmaceutic interventions were documented.  Review of the nursing progress not from 07/04/12 - 07/09/12 indicated there was no documentation of any insomnia behavior. Nursing notes, from 07/10/12 - 07/11/12 indicated there was no documentation again any increased insomnia issues.  Nursing notes, from 07/12/12 - 07/27/12 indicated on 07/18/12 the resident had some insomnia around 4:00 A.M., however the resident was being tested for a possible urinary	s FULL ATION)  ent jh - ly ome al  tes	STREET A	JEFFERSON BLVD	IN BE	(X5) COMPLETION DATE
tract infection. On 07/23/12 the resident's husband informed staff tresident was anxious and not sleeping well. The urinalysis test vistill pending with the laboratory at time. There were no interventions besides family at bedside and medications documented as having been attempted regarding the insomnia.	vas the				

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Event ID: YQ0S11

Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155756	B. WIN	IG		10/19/	2012
NAME OF P	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		0/19/12 at 8:45 A.M.,					
	with the Directo	•					
		nployee #10, indicated					
		ne Corporate Social					
		id a "webinar" inservice					
	1	cial service staff					
		sychotic reduction					
		regards to CMS					
		en the Corporate Social					
		conducted "conference					
		ity Social Services staff					
	throughout the	summer.					
		Social Services					
	· ·	10/19/12 at 10:00					
		d the facility is working					
		ividual tracking plan to					
		behavior and care					
	plans were in p	place for residents					
	receiving antip	sychotic medications.					
	4 The clinical	record for Resident					
		ved on 10/17/12 at					
	1:30 P.M. Res						
		e facility on 08/04/2007					
		s including but not					
		(cerebral vascular					
		eimer's, Osteoporosis,					
	·	ion), allergic rhinitis,					
		behavior disturbance,					
	delusions, dep						
	' '	, hypothyroidism,					
		eft hemiplegia,					
		dy cardiac, and pvd					
		•					
	l (heribilerai vas	scular disease).					

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Event ID: YQ0S11

Facility ID: 004945

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155756	A. BUILDING B. WING	<del></del>	10/19/2012
NAME OF I	DROWNER OR GURRI IER			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER			V JEFFERSON BLVD	
COVENT	RY MEADOWS		FORT	WAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
	Review of the prindicated an or the antipsychologyprexia.  Review of a "B dated 05/10/12 the resident was out "help" loudhair, and attem redirected. The to a quiet area order for the ar Ativan was obturinalysis test was resident had cuantibiotic medicinfection.  Review of nurs behavior tracking indicated there behaviors documented the episodes or wandering in other resident's non-pharmaced attempted were	chysician's orders der, dated 07/31/12 for tic medication,  ehavior Events" note, at 4:23 P.M. indicated as exit seeking, yelling by, scratching, pulling apting to bite staff when the resident was moved and given space. An antianxiety medication, ained. In addition, a was obtained. The arrently been receiving cation for an eye  ing progress notes and ang forms for May 2012 were no other amented to support the rexa for Resident #80.  Ing records for June on 06/11/12 on the are resident exhibited of either exit seeking in her wheelchair into			

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Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155756	B. WIN	G		10/19/	2012
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	' '	eased the resident's					
	, , ,	ng at bedtime due to					
	dementia with	behavioral					
	disturbances.						
		current through					
		ated a plan to address					
		resistiveness to care.					
	•	ated the resident would					
	*	ite, scratch, pinch to					
		ne does not want to get					
		are. There was also a					
	plan regarding						
	delusional beh						
	delusions and	resistive behaviors					
	were not being	tracked on the					
	behavior tracki	ng records					
	•	10/19/12 at 11:00					
	· ·	h Social Service					
	Directors, emp	loyees #4 and 5					
	indicated they	had only been at the					
	_	ort time and did not feel					
	they could disc	cuss Resident #80's					
	psychotropic m	nedications and/or					
	behaviors.						
	5. Resident #2	47's record was					
	reviewed 10-17	7-2012 at 10:37 AM.					
	Resident #247	's diagnoses included					
	but were not lir	mited to dementia, high					
	blood pressure	and an enlarged					
	heart.	-					
	A review of a c	urrent physician's					

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Event ID: YQ0S11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155756	B. WIN			10/19/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
					V/(114E, 114 16661		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		/ dated 10-2012					
		ıx (an antianxiety					
	,	5 milligrams (mg) had					
	been ordered of	every 6 hours as					
	necessary for a	anxiety.					
	A review of the	Medication					
	Administration	Record (MAR)					
		ent #247 had received					
	Xanax 0.5 mg	10-13, 10-15, and					
	_	ety. A note on the back					
		MAR indicated all					
		ective. There was no					
		pharmacological					
	interventions n	ad been attempted.					
		on 1-17-2012 at 11:08					
		dicated interventions					
	attempted prio	r to as necessary					
	dosing were or	n the back of the MAR					
	or in nurse's no	otes.					
	A care plan title	ed depression as					
	•	earfulness, sad					
	,	d verbalization dated					
	•	cluded interventions of					
		voice emotions, refer to					
	_						
		needed, talk to					
		favorite things, and					
	redirect to an a	activity.					
		care plan that included					
	anxiety, or anx	iety medication use.					
	In an interview	on 10-17-2012 at 1:12					

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Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155756	B. WIN			10/19/	2012
NAME OF B			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		7843 W	JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	VAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		dicated behavior					
	tracking was o	n the MAR.					
		on 10-17-2012 at 1:13					
		dicated behavior					
	_	the MAR. She further					
		dent #247 had not been					
		as she knew for					
		N #1 further indicated					
	•	logical intervention					
	should have be	een attempted before					
	as necessary	Xanax was used.					
	In an interview	on 10-17-2012 at 1:15					
	PM SSD #4 in	dicated no behavior					
	had been track	ked because the					
	physician had	just changed the					
	medications ar	nd there was no					
	tracking neces	sary. SSD #4 further					
		should have been a					
	care plan addr	essing use of Xanax					
	and anxiety.	G					
	6. Resident #	151's clinical record					
	was reviewed	on 10/17/12. The					
	record indicate	ed the resident was					
		e facility on 9/12/12 and					
		s including, but not					
	_	entia with delusions					
	and depression						
	3 GOP. GOO!	<del></del>					
	Review of resid	dent # 151's physician's					
		ed the resident has					
	been receiving						
		Trapolati (all					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/19/2012	
	PROVIDER OR SUPPLIE	R	7843 \	ADDRESS, CITY, STATE, ZIP CODE W JEFFERSON BLVD WAYNE, IN 46804	•
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	milligrams (mg	medication) 0.25 g) by mouth at bedtime with delusions since			
	plans, current indicated there plan for demen	resident's health care through 12/11/12, e was no health care ntia with delusions. No ans were located for the dal.			
	at 1:15 p.m. in had no health	vith LPN #5 on 10/17/12 dicated the resident care plan related to for dementia with			
	director of nurse at 1:20 p.m. in tracking for res medication ad (MAR). The Al	vith the assistant sing (ADN) on 10/17/12 dicated behavior sidents was kept in the ministration records DN indicated review of s MAR did not contain racking.			
	Social Service #15, on 10/17 resident had n	with resident #151's coordinator, employee 7/12, indicated the to health care plan for delusions and no ing.			
	3.1-35(a)				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CC  A. BUILDING  B. WING	00				
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
				(EACH CORRECTIVE ACTION S	SHOULD BE			

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Event ID: YQ0S11

Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155756		LDING		10/19/	2012
		100700	B. WIN			10/10/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THE OF T	NO VIDER OR SOLVER			7843 W	/ JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	483.20(k)(3)(ii)					,	
SS=D	SERVICES BY Q	UALIFIED PERSONS/PER					
	CARE PLAN						
	The services prov	vided or arranged by the					
	facility must be pr	ovided by qualified					
	persons in accord	lance with each resident's					
	written plan of car	re.					
	Based on obse	rvation, interviews, and	F02	82	F 282 Services by qualified		11/18/2012
		he facility failed to			persons/per care plan		
	ensure a care p				It is the practice of this facility	to	
		st restraint as a			ensure that care plans are car	ried	
	•				out by qualified persons.		
	reduction plan						
	•	1 of 1 residents			What corrective action(s) will	I	
	reviewed for re	straints. (Resident			be accomplished for those		
	#198)				residents found to have beer	1	
	,				affected by the deficient		
	Finding include	e.			practice:		
	i iliuling iliciuue	·5.			· Resident #198 restraint	will	
					be released during meals,		
		12:25 P.M., Resident			personal care, and while unde		
	#198 was obse	rved seated at a dining			direct supervision of staff to be	e in	
	room table on t	he secured dementia			compliance with restraint		
	unit The resid	ent was seated in her			reduction per plan of care.		
		a seatbelt type			l		
					How will you identify other		
	•	ce. The resident was			residents having the potentia	31	
		n meal and was noted			to be affected by the same		
	to be able to fe	ed herself.			deficient practice and what		
					corrective action will be take		
	On 10/17/12 at	1:47 P.M., Resident			No other Residents wer  affected by this alleged deficie	_	
		propelling self in			affected by this alleged deficie	ent	
		und secured unit. The			practice.  No other residents have		
					restraints in the building.	•	
		seat belt type waist			restraints in the building.		
		e resident was asked			What measures will be put in	ito	
	if she could ren	nove the seatbelt and			place or what systemic		
	the resident wa	is cued to the seat belt			changes will you make to		
	clasp. Resider	nt stated "Probably so"			ensure that the deficient		
	•	w through and try to			practice does not recur:		
	but did 110t 1011C	w through and try to			practice does not recur.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPLE	TED
		155756	B. WING	-	10/19/2012		
NAME OF T	DOMDED OF GLIDE IE.			REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	ζ.	78	343 W .	JEFFERSON BLVD		
	RY MEADOWS				'AYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA	.G		:	DATE
IAG	Observation 10 Resident #198 wheelchair in the secured unwaist restraint resident was a in finish the phane. A.M., the unit resident in her lounge to the cresident's waist released. The to remained sewith a waist restraint remained received her mup for her to expression to the facility of the facility	olds/12 11:15 A.M., was seated in her he day lounge area of hit. The seatbelt type was in place. The wake and participated rase activity. At 11:58 manager propelled wheelchair from the dining room table. The het restraint was not resident was observed eated in her wheelchair estraint in place through he resident had heal, had her food set hat, but the waist ned in place and was  cord for Resident #198 on 10/18/12 at 8:49 lent had been admitted n 07/03/12. Nursing sician orders indicated hit was initiated on  care plan regarding or Resident #198, 16/12 and current 12, indicated the			A restraint flow sheet wibe placed in resident #198 MA to ensure restraint is being released per plan of care. The licensed nurse will conduct rounds to ensure compliance of all three shifts. See Exhibit C.  The Staff Development Coordinator/Designee will in-service all licensed staff on before November 18, 2012 on restraint policy.  How the corrective action(s) will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place.  A CQI monitoring tool called Physical Restraints will utilized every week x 4, month 3 and quarterly x 2 for at least months. IDT to review CQI to an action plan will be implemented if threshold of 95 is not met. See Exhibit E. Data will be collected by DNS/Designee from 1 st and 2 shifts submitted to the CQI committee. If threshold of 95% not met, an action plan will be developed.  Non-compliance with facility procedures may result in disciplinary action up to and including termination.  Completion date: 11/18/12	or the he cur, he collection be sur, he collection be coll	DATE
ı	_	ction plan: may be			Completion date: 11/18/12		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER:  155756	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLE S	ETED		
	ROVIDER OR SUPPLIER RY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	released at meals, during personal care, while in bed, and when under direct supervision of staff or family.  3.1-35(g)(2)						

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Facility ID: 004945

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155756	B. WING		10/19/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		/ JEFFERSON BLVD	
COVENT	RY MEADOWS			WAYNE, IN 46804	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0329 SS=E	UNNECESSARY Each resident's of from unnecessary drug is any drug dose (including of excessive durating monitoring; or with for its use; or introduced combinations of the second combinations who is receive gradual of the second combination contraindicated, these drugs.  Based on observations of the second combination for the second combination	drug regimen must be free ry drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate ithout adequate indications the presence of adverse which indicate the dose ed or discontinued; or any the reasons above.  The prehensive assessment of a still y must ensure that ave not used antipsychotic wen these drugs unless and the clinical record; and the clinical record; and the antipsychotic drugs dose reductions, and tentions, unless clinically in an effort to discontinue the revation, record review, so, the facility failed to	F0329	F 329 Drug Regimen is free from unnecessary drugs It is the practice of this facility ensure that each Resident's d regimen is free from unnecess drugs. Anti-psychotic drugs a not to be given unless to treat specific condition/diagnosis alwith supportive documentation that meets criteria from CMS twarrant the need for that medication. GDR's will then be implemented in an effort to discontinue the medication un clinically contraindicated.	rug sary re a ong n o

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Event ID: YQ0S11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIVI	DDIG	00	COMPLETED
		155756	A. BUII B. WIN	LDING		10/19/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>
NAME OF P	PROVIDER OR SUPPLIE	R			/ JEFFERSON BLVD	
COVENT	RY MEADOWS				WAYNE, IN 46804	
	INT MILADOWS			TOKT		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	(Residents #18, 41, 80, 151, 165,				l	
	175, and 247.	)			What corrective action(s) will	i <b>l</b>
					be accomplished for those	
	Findings include	de:			residents found to have bee	n
	J				affected by the deficient	
	1 The clinical	record for Resident			practice:	
		wed on 10/18/12 at			· Interdisciplinary Team	
					(IDT) will review residents #18	3.
		sident #41 was			#41, #80, #151, #165, #175, #	
		e facility on 07/27/12			affected by the alleged deficie	I
	from an acute care hospital. The resident's diagnoses included but were not limited to: Acute T2 T3 compound fracture, falls, dementia,				practice using the CQI	
					psychotropic medication track	ing
					form tool. To ensure	
					non-pharmaceutical interventi	
	osteoporosis,	glaucoma,			are attempted prior to the use	
	venous-statis,	•			the anti-anxiety/anti-psychotic medications and to ensure	·
		d compression fracture.			behavior monitoring of medica	ا
	Syriaronic, and	d compression nacture.			symptoms is documented. So	
	Nursing progr	and notice dated			Services will discuss with the	
	• • •	ess notes, dated			psychiatric clinician or neurolo	ogist
		46 P.M. indicated the			on or before 11/18/12 regarding	ng
		ipset about being at the			psychotropic medication	
	facility and wa	nted to go home. She			management for those reside	nts
	moved her wh	eelchair backwards into			that were affected and make	
	the wall in frus	tration and the handle			necessary changes as	trio
	of the wheelch	air put a hole in the			recommended by the psychia clinician or neurologist.	unc
	wall.	•			Cirrician of fleurologist.	
	, . <del></del>					
	On 08/04/12	at 10:06 P.M., the			How will you identify other	
		•			residents having the potenti	al
		ne upset because her			to be affected by the same	
		contain all of her			deficient practice and what	
		dition the resident			corrective action will be take	n:
	continued to w	ant to go home.				
					<ul> <li>No other residents were</li> </ul>	-
	On 08/05/12 a	t 6:37 P.M., the			found to have been affected b	у
	resident was a	igitated again and			the alleged deficient practice.	
		nome. She kept asking			· Residents having	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155756	B. WIN			10/19/2012	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	PROVIDER OR SUPPLIE	R			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
					VATIVE, IIV 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		i
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	_
		her a ride. An order for			psychotropic medications have		
	Ativan was obt	ained.			the potential to be affected by alleged practice.	tne	
	On 08/06/12 at 10:00 P.M., the				Licensed staff and		
					members of the interdisciplinar	·v	
	resident again	expressed the desire			team including social services	-	
	_	Staff explained why			be in-serviced on the behavior		
	_	facility and gave her a			management program includin	g	
	pain pill and sh				gradual dose reductions.		
		ie was camer.			Education will be provided by		
	On 09/07/12 o	t 1:00 D M the resident			Social Services Consultant/Designee and		
	On 08/07/12 at 1:09 P.M. the resident was again upset about the "missing clothes" in her closet and wanted to go home. An order for a urinalysis				completed by November 18 th		
					2012.	,	
					· A house audit will be		
					implemented by Social Service	es	
	was obtained.				and will begin using a tool for		
					tracking of psychotropic		
	On 08/08/12 a	t 12:22 A.M., Resident			medications for those resident	S	
	#41 was agitat	ed again about her			who are on psychotropic medications to ensure that all		
	missing clothe	s. The resident thought			residents are free from		
	_	me" and her clothes			unnecessary drugs. All new		
		n from her closet. The			admissions and readmissions	are	
		xplained she only			reviewed in a.m. meeting with	IDT	
	_	s and two were in the			to ensure the care plan,		
	_	re in the hamper, and			diagnosis, behavior tracking flo		
		laundry. The resident			sheets are individualized and i	n	
		,			place. See Exhibit A.		
		ad a "whole closet full					
		taff then "quizzed" her			What measures will be put in	to	
	about the nam				place or what systemic	.	
	`	facility resident had			changes you will make to		
	been residing i	in prior to fall).			ensure that the deficient		
					practice does not recur:		
	On 08/09/12 a	t 9:22 A.M., the					
	resident again	began repeatedly			· Licensed staff and		
	_	"things." She indicated			members of the interdisciplinal		
	_	s, her purse, and her			team including social services		
		Staff attempted to			be in-serviced on the behavior		
	Julioi Stull.	ran attempted to			management program includin	9	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED
		155756	A. BUI. B. WIN			10/19/2012
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	₹			/ JEFFERSON BLVD	
COVENT						
COVENT	RY MEADOWS			FORT	WAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	reorient the res	sident but she became			gradual dose reductions.	
	very distraught, did not believe the				Education will be provided by	
	staff, thought her items had been				Social Services	
					Consultant/Designee and	
	stolen. The resident was given Ativan to help her "rest."				completed by November 18 th 2012.	,
		J.,			Prior to the licensed nur	20
	0= 00/40/40	4.4.4.0 A M. 45			administration of any prn	
		t 11:16 A.M., the			medication or any new order of	f
		d asking to go home.			psychotropic medication the	
	The resident a	sked staff and visitors			DNS/designee will be notified	to
	for a ride home	e, asked to call her			ensure non-pharmaceutical	
	family. She th	en became agitated			interventions are implemented	
	because she was not in her "home."				· IDT to review all	
		ected and informed			medication orders using the to	ol
		and therapy would			for tracking of psychotropic medications to ensure behavious	ar .
		sue with her tomorrow			management tracking and to	) 
					ensure residents are free of	
		her discharge plans.			unnecessary medications. Se	ne l
		he resident became			Exhibit A	
	l —	oud, tried to exit the			DNS is responsible to overs	see
	facility repeate	dly. The resident was			compliance.	
	medicated with	n Ativan for anxiety and				
	given 1:1 atter	ition which was				
	effective.				How the corrective action(s)	
					will be monitored to ensure t	
	On 08/13/12 #	ne resident's attending			deficient practice will not rec	ur,
		· ·			i.e., what quality assurance	
	' "	r Haloperidol, an			program will be put into plac	e:
	antipsychotic r					
	l '	antidepressant			·A CQI monitoring tool called	
	medication wit	h sedating side effects.			Unnecessary Medications will	II
					utilized every week x 4, month	II
	A physician's r	note, dated 09/07/12,			3 and every other month x 3 for	-
		laloperidol was ordered			months. See Exhibit F	
	due to "delusio				Data will be collected by	
					DNS/Designee and submitted	
	On 9/21/12 a	note to physician			the CQI Committee. If thresho	ld
		note to physician,			of 95% is not met, an action pl	an
	indicated the i	resident continued to			will be developed.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155756	B. WIN			10/19/	2012
		<u> </u>	В. W II.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	have problem	behaviors through past			·Non-compliance with facility	/	
	week - scream	ing and hitting staff			procedure may result in		
	when they don	I't open the door for her			disciplinary action up to and		
	or ask her to si	•			including termination.		
		sked to change Haldol					
	and Trazadone to Risperidone. The request was not responded to by the						
					Completion date: 11/18/12		
	physician.						
	0= 00/04/40						
	On 08/24/12 a						
		cated the resident has					
	, ,	olem behaviors in the					
	past week. Sh	ne was "exit seeking,					
	ramming w/c ir	nto staff, scratching,					
	screaming at s	staffher moods					
	worsen at 6 PM	MAtivan seems to					
	help her to cal	m but takes awhile."					
	Review of the	behavior tracking for					
	Resident #41 f	or August 15 - 31,					
	2012 indicated	lit tracked the following					
	behaviors:	-					
	#1 - anxietv ae	eb [as evidenced by] [as					
	_	[as evidenced by] [as					
	* -	[as evidenced by]					
	,	vorrisome thoughts					
		e stealing her things					
		s steaming her tillings					
	and	ach Ion avidonaed by					
		aeb [as evidenced by]					
	_	by] [as evidenced by]					
	-	by] [as evidenced by]					
		- 8 hours daily.					
	There were no	behaviors noted on					
	the tracking for	rm for August 2012.					
	-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155756	B. WIN	IG		10/19/	2012
NAME OF I	PROVIDER OR SUPPLIEF	<b>\</b>			ADDRESS, CITY, STATE, ZIP CODE		
COVENT				1	JEFFERSON BLVD		
	RY MEADOWS			<u> </u>	VAYNE, IN 46804	1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
	An October 20 form indicated were being trace #1 - anxiety are evidenced by] evidenced by] fidgeting and we such as people #2 - Insomnia #3 - Verbal and agitation/aggreation/aggreation/aggreation/aggreation/aggreation for whom to be a such as people #2 - Insomnia #3 - Verbal and agitation/aggreation/aggreation/aggreation.  There was no locate plan to addition, prior to the plan addition, prior to the plans for Resident included a plan for aggressive initiated on 08/and a plan, initial anxiety. There initiated prior to administration antipsychotic, a medication.  Interview with Intervi	12 behavior tracking the following behaviors cked: b [as evidenced by] [as [as evidenced by] [as [as evidenced by] worrisome thoughts e stealing her things d physical ession. Dehavioral tracking or ldress the delusional nich the resident was ered, Haldol. In to the order for the was no documentation					

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Event ID: YQ0S11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155756	B. WIN			10/19/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			JEFFERSON BLVD		
COVENT	RY MEADOWS			1	VAYNE, IN 46804		
					VATIVE, IIV 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		nployee #10, on					
	10/19/12 at 11	:00 A.M, indicated					
	the physician v	vho had taken care of					
	resident while	she was in an assisted					
	living facility had ordered the Haldol						
	and indicated the reason was						
	delusions. The Nurse Consultant						
	indicated she was checking with the						
		ee if there was anymore					
	' '	-					
	in site as to the reason Haldol was						
	ordered. There was no further						
	information obtained from the						
	1 * *	e time of the survey					
	exit for the faci	lity.					
	2. The clinical	record for Resident					
	#18 was review	ved on 10/18/12 at					
	10:00 A.M. Re	esident #18 was					
	admitted to the	e facility on 05/22/2008,					
		s including but not					
		ression with withdrawal					
	and decreased						
		•					
	• •	flux, personality					
		orderline features, hx					
	1	y, ddd, htn, moderate					
	1	sed cholesterol, djd,					
	dementia, bipo	lar disorder, delusions,					
	gerd, seasonal	l allergies, dry eye, oad,					
	hyperlipidemia	, and diabetes mellitus.					
	Review of the	physician orders for					
	l '	ndicated she was					
		ictal, a mood altering					
	_	_					
		xaclo, an antipsychotic					
	medication, Na	amenda, a medication					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155756	B. WIN	G		10/19/	2012
NAME OF P	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		tia, and Exelon patch,					
	an antidepress	ant medication.					
	Review of the current behavior						
	tracking and he	ealth care plans, for					
		for Resident #18					
	indicated the fo	ollowing behaviors were					
	being tracked:						
	#1 - Hx of alter	ration in mental process					
	with potential f	or injury to self, family					
	members and/	or staff and #2 -					
	Manipulative b	ehavior.					
	Interview with	Social service					
	designee, emp	loyee #5, on 10/19/12					
	at 11:00 A.M. i	ndicated she had not					
	been working i	n the facility very long					
	and was not al	ole to discuss behavior					
	tracking and ar	ntipsychotic medication					
	use for Reside	nt #18.					
	Interview with	the Social services					
	consultant, em	ployee #10, on					
		:10 A.M., indicated the					
		rding behavior tracking					
		18 was not clear as to					
	what to what t	he actual behavior					
	being tracked.						
	3. The clinical	record for Resident					
		ewed on 10/18/12 at					
		resident was admitted					
		n 10/19/11 and					
	1	he facility on 07/02/12					
		, including but not					
	diagnosis,	,o.aanig bat not					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155756	A. BUI	LDING	00	COMPLE 10/19/2	
		100700	B. WIN		DDDEGG GUTY GTATE TID GODE	10/13/2	-012
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE  JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		with fracture and scalp					
	lacerations, se						
	insomnia, anemia, anxiety, and hx of urinary tract infection.  Physician's orders, dated 04/20/12						
		der for Ativan .5 mg					
		as needed for anxiety.					
	On 05/03/12 a	n order was received					
	for Ativan .5 m	g every 8 hours					
	,	xiety. On 05/10/12 an					
		the as needed Ativan					
		for anxiety induced by					
		g with the routinely					
		as long as the resident					
		more than 2 mg of					
	Ativan in a 24	nour period.					
	A care plan red	garding anxiety was not					
	initiated until 0						
	The resident w	as readmitted for an					
		lity on 07/04/12.					
	•	ers on 07/04/12					
		esident was receiving					
		anxiety medication,					
	_	d as needed for anxiety					
	_	n, and Keelson patch					
	for depression						
	anuuepressani	t, Remeron at bedtime.					
	On 07/09/12 a	n order for Ambien, a					
		ordered at bedtime per					
		st due to insomnia. On					

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Event ID: YQ0S11

Facility ID: 004945

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AND PLAN OF CORRECTION DESTIFICATION NUMBER: 155756 B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS  (X4) ID PREFIX TAG  O7/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat  STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  (X5) PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (X5) COMPLETION DATE  (X5) COMPLETION DATE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
TRAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  O7/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat  TAS SUMMARY STATEMENT OF DEFICIENCY  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (CACH CORRECTION SHOULD			100700	_		10/19/2012
COVENTRY MEADOWS  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  O7/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat	NAME OF P	PROVIDER OR SUPPLIER				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY)  (EACH DEFICIENCY)  (EACH DEFICIENCY)  (EACH DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMPLETION DEFICIENCY)  (COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMPLETION DEFICIENCY)  (COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMPLETION SHOULD	COVENT	RY MEADOWS				
TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  O7/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		` ′
07/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat		`			CROSS-REFERENCED TO THE APPROPR	SIATE CONTINUE TO T
discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat	TAG		· · · · · · · · · · · · · · · · · · ·	TAG	DEFICIENCY)	DATE
received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat		· ·				
bedtime, may repeat one time a night due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat						
due to insomnia.  On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat		bedtime, may repeat one time a night				
On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat						
Lunesta 2 mg at bedtime was added for insomnia, a medication to treat						
Lunesta 2 mg at bedtime was added for insomnia, a medication to treat		On 07/27/12 ar	nother hypnotic			
for insomnia, a medication to treat			* ·			
		_				
I I GOLIGOO ICU OYIIUIUIIIC, LYIIUA WAO I I IIIIIIIIIIIIIIIIIIIIIIIIIIIIII		· · · · · · · · · · · · · · · · · · ·				
also added.						
Review of the care plans for Resident		Review of the	care plans for Resident			
#175 indicated plan, current through		#175 indicated	plan, current through			
12/11/12 for Behavioral symptoms -		12/11/12 for Be	ehavioral symptoms -			
signs and symptoms of anxiety,		signs and sym	otoms of anxiety,			
insomnia, and depression. The only			•			
plan to address restless leg syndrome		-				
indicated a plan to administer the		· ·				
medication. No non-pharmaceutical			-			
interventions were documented.		interventions w	ere documented.			
Doublew of the purping progress notes		Davieus et the				
Review of the nursing progress notes						
from 07/04/12 - 07/09/12 indicated						
there was no documentation of any insomnia behavior. Nursing notes,			•			
from 07/10/12 - 07/11/12 indicated			•			
there was no documentation again of						
any increased insomnia issues.			•			
Nursing notes, from 07/12/12 -		1				
07/27/12 indicated on 07/18/12 the						
resident had some insomnia around						
4:00 A.M., however the resident was						
being tested for a possible urinary		<u> </u>				

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Event ID: YQ0S11

Facility ID: 004945

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		A. BUILDING 00  B. WING	COMPLETED 10/19/2012			
	PROVIDER OR SUPPLIER TRY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE			
	tract infection. On 07/23/12 the resident's husband informed staff the resident was anxious and not sleeping well. The urinalysis test was still pending with the laboratory at the time. There were no interventions besides family at bedside and medications documented as having been attempted regarding the insomnia.  Interview on 10/19/12 at 8:45 A.M., with the Director of Nursing Consultant, employee #10, indicated in June 2012 the Corporate Social Service staff did a "webinar" inservice with facility social service staff regarding antipsychotic reduction action plans in regards to CMS initiatives. Then the Corporate Social Services staff conducted "conference calls" with facility Social Services staff throughout the summer.  Interview with Social Services Consultant, on 10/19/12 at 10:00 A.M., indicated the facility if working towards an individual tracking plan to make sure the behavior and care plans were in place for residents receiving antipsychotic medications.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE	
AND FLAN	OF CORRECTION	155756		LDING	00	10/19/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	4 The clinical	record for Resident					
		wed on 10/17/12 at					
	1:30 P.M. Resident #80 was admitted to the facility on						
		h diagnoses including					
		to: CVA (cerebral					
		ent), Alzheimer's,					
		htn (hypertension),					
	allergic rhinitis,	dementia with					
		bance, delusions,					
	depression, hy	T					
		i, osteoarthritis, left					
		mentia, Brady cardiac,					
	and pvd (peripl	neral vascular					
	disease).						
	Review of the r	physician's orders					
	-	der, dated 07/31/12 for					
	the antipsycho						
	Zyprexia.	,					
		ehavior Events" note,					
		at 4:23 P.M. indicated					
		as exit seeking, yelling					
	•	y, scratching, pulling					
	-	pting to bite staff when					
		e resident was moved					
	•	and given space. An ntianxiety medication,					
		ained. In addition, a					
		was obtained. The					
	_	urrently been receiving					
		cation for an eye					
	infection.	<b>, -</b>					
	1						

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Event ID: YQ0S11

Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155756	B. WIN			10/19/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	· ·		7843 W	JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	behavior tracki indicated there	sing progress notes and ing forms for May 2012 were no other umented to support the					
	use of the Zyprexa for Resident #80.						
	Behavior track	ing records for June					
	2012 indicated	on 06/11/12 on the					
	evening shift th	ne resident exhibited					
	three episodes of either exit seeking						
	or wandering in	n her wheelchair into					
	other resident's	s rooms. The					
	non-pharmace	utical interventions					
	attempted were	e documented as					
	effective. How	vever, on 06/12/12, the					
	physician incre	eased the resident's					
	Zyprexa to 5 m	ng at bedtime due to					
	dementia with	behavioral					
	disturbances.						
		current through					
		ated a plan to address					
		resistiveness to care.					
		ated the resident would					
	*	ite, scratch, pinch to					
		ne does not want to get					
		care. There was also a					
	plan regarding						
	delusional beh	•					
		resistive behaviors					
	_	tracked on the					
	behavior tracki	ing records					
	Interview, on	10/19/12 at 11:00					

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Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155756		LDING	00	COMPL 10/19/	
		100700	B. WIN		DDRESS, CITY, STATE, ZIP CODE	10/10/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		k LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCT)		DATE
	· ·	h Social Service lloyees #4 and 5					
		had only been at the					
	1	•					
	facility for a short time and did not feel they could discuss Resident #80's psychotropic medications and/or behaviors.						
	5. Resident # 151's clinical record						
	was reviewed on 10/17/12. The						
	record indicated the resident was						
	admitted to the facility on 9/12/12 and						
	had diagnoses including, but not						
		entia with delusions					
	and depression	n.					
	Dovious of roois	dont # 151's physician's					
		dent # 151's physician's ed the resident has					
	been receiving						
	_	nedication ) 0.25					
		) by mouth at bedtime					
	, , ,	vith delusions since					
	admission.						
	Review of the	resident's health care					
	plans, current	through 12/11/12,					
		ealth care plan for					
		delusions. No health					
	· ·	e located for the use of					
	Risperdal.						
	An interview w	rith LPN #5 on 10/17/12					
		dicated the resident					
	•	care plan related to					
		for dementia with					

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Event ID: YQ0S11

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE ( COMPL 10/19/	ETED	
NAME OF F	ROVIDER OR SUPPLIER			REET AI	DDRESS, CITY, STATE, ZIP CODE			
COVENTRY MEADOWS			7843 W JEFFERSON BLVD FORT WAYNE, IN 46804					
(X4) ID					ATINE, IN 40004		(V5)	
PREFIX			II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG			TA	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	delusions.							
	director of nurs at 1:20 p.m. ind tracking for res medication adr (MAR). The AD resident #151's any behavior to An interview w Social Service #15, on 10/17, resident had no	ith resident #151's coordinator, employee /12, indicated the o health care plan for delusions and no						
	reviewed 10-19 Resident #165 but were not lir psychosis, dep A review of the order sheet inc antidepressant had been presidepression and	65's record was 9-2012 at 10:02 AM. 's diagnoses included mited to dementia with pression, and agitation.  current physician's licated Prozac (an 2) 20 milligrams (mg) cribed every day for d Risperdal 0.25 mg ii ementia with psychotic						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X. A. BUILDING			X3) DATE SURVEY COMPLETED		
		155756	A. BUII B. WIN			10/19/2012	
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	threatening oth for periods of a Resident #165 verbalize include the interventior indicated medicated medicated threatening oth formation (MI 2-28-2012, 5-2 indicated no medicated no medications as changes in rouchanges in fee There were no pharmacological.	viors of yelling and ters. Behavior tracking anxious moods was not able to ded no behaviors, but as of meds as ordered cations had been given sence of behavior.  The se's notes from May ar 2012 indicated no  Minimum Data Set DS) for the periods of 3-2012, and 8-15-2012 coods, delusions/or behaviors in the ference periods.  The sed 11-9-2011 titled resident is unable to ded interventions of a ordered, observe for tine that may indicate lings of anxiousness. other non al interventions.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIH	A. BUILDING 00			COMPLETED		
155756		B. WING 10/19/2012			2012			
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
COVENTRY MEADOWS				7843 W JEFFERSON BLVD FORT WAYNE, IN 46804				
					V////42, IIV 10001			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
PREFIX				PREFIX		CROSS-REFERENCED TO THE APPROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
		n an understanding of						
	•	ns and outcomes you						
	would like to se	ee, orient resident to						
	his surrounding	gs,and talk with						
	resident in calr	m voice and manner.						
	A care plan title	ed diagnosis of						
	•	luded interventions of						
		rom day room and						
		ne resident likes and						
	· ·							
	interest, and introduce to residents with similar interests.							
	With Similar into	eresis.						
	A care plan titled dementia dated 9-19-2011 included interventions of							
		going support from						
	family, introduc	ce to other residents						
	with similar into	erests, introduce self at						
	each interaction, and show resident the common area of the facility.							
	In an interview	on 10-19-2012 at						
	12:08 PM LPN	I #2 indicated she was						
	unsure if the R	risperdal or Prozac was						
		r anxiety. LPN #2						
	further indicated staff should be attempting nonpharmacologic							
		. •						
	interventions d							
	medications for depression and							
	dementia with	delusions.						
		47's record was						
		7-2012 at 10:37 AM.						
	Resident #247	's diagnoses included						
	but were not lii	mited to dementia, high						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		155756	B. WIN	IG		10/19/	2012
NAME OF B	AN OLUMBER OR GUIDRU IEE			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		7843 W	JEFFERSON BLVD		
COVENTRY MEADOWS				FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		The complete of the complete o		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE .	DATE
	blood pressure, and enlarged heart.						
		•					
	A review of a c	current physician's					
		/ dated 10-2012					
		ax (an antianxiety					
		5 milligrams (mg) had					
	· · · · · · · · · · · · · · · · · · ·	,					
		every 6 hours as					
	necessary for a	anxiety.					
	A review of the	Modication					
	Administration	, ,					
		ent #247 had received					
	Xanax 0.5 mg 10-13, 10-15, and 10-16-2012 for anxiety. A note on the						
	back of the Oc	tober MAR indicated all					
	doses were effective. There was no						
	indication non-	pharmacological					
	interventions h	ad been attempted.					
		•					
	In an interview	on 1-17-2012 at 11:08					
	AM LPN #1 in	dicated interventions					
		r to as necessary					
		-					
	dosing were on the back of the MAR or in nurse's notes.						
	A review of Nu	rse's notes dated					
		and 10-16-2012 did not					
	· · · · · · · · · · · · · · · · · · ·						
	reveal any mer						
	administration of Xanax or of the						
	_	ng the medication or					
	any non-pharmacological attempt						
	prior to it's adn	ninistration.					
	•	ed depression as					
	evidenced by t	earfulness, sad					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756		LDING	NSTRUCTION  00	(X3) DATE : COMPL 10/19/	ETED	
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE  7843 W JEFFERSON BLVD  FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
IAU	expression, an 10-12-2012 incencourage to we psychiatrist as resident about redirect to an all In an interview PM SSD #4 incention was used.  In an interview PM LPN #1 incention was indicated non printervention shattempted before was used.  In an interview PM SSD #4 incention was used.  In an interview PM SSD #4 incention shattempted before was used.	d verbalization dated cluded interventions of voice emotions, refer to needed, talk to favorite things, and activity.  on 10-17-2012 at 1:12 dicated behavior in the MAR.  on 10-17-2012 at 1:13 dicated behavior in the MAR. She further dent #247 had not been as she knew for existy. LPN #1 further charmacological ould have been one as necessary Xanax  on 10-17-2012 at 1:15 dicated no behavior ted because the just changed the end there was no sary. SSD #4 further e should have been non all attempts prior to the		IAU			DATE	
	3.1-48(b)(1) 3.1-48(b)(3) 3.1-48(b)(4) 3.1-48(b)(5)							

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 10/19/	ETED			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD						
COVENT	RY MEADOWS		FORT WAYNE, IN 46804						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE			

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Event ID: YQ0S11

Facility ID: 004945

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